STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445099	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, ATHENS	1204 FRYE ST ATHENS, TN 37303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barrier walls were maintained. The findings include: Observation and interview with the Maintenance Director, on July 29, 2013 at 3:15 p.m. confirmed the smoke wall above the smoke doors by rooms 101, 120, and stairwell had unsealed penetrations above the lay-in ceiling. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 29, 2013.	K 025	1. The smoke wall penetrations above the smoke doors by rooms 101, 120, and stairwell have been sealed. 2. No other areas were found to be affected by same occurrence. 3. Maintenance Director will check for smoke wall penetrations at least annually. 4. Smoke wall penetrations are on the annual safety checklist.	8/31/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dunte Davis
TITLE: Administrator
(X6) DATE: 8-12-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 12 2013

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K 029	Continued From page 1 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure rooms protected as hazardous, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on July 29, 2013 at 2:15 p.m. confirmed the activity room door was not provided with a door closer. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 29, 2013.	K 029	1. Activity Room door has been provided with a door closer. 2. No other areas were found to be affected by the same occurrence. 3. Maintenance Director has been instructed on door closers needed in rooms protected as hazardous. 4. Rooms protected as hazardous will be included on the building safety checklist.	8/31/13
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to illuminate exit	K 045	1. Outside emergency exit lighting was added to station 2 long hall and exit by laundry lighting the public way. 2. All exits have been identified and have emergency exit lighting to the public way. 3. Maintenance Director has been instructed on proper emergency lighting at exits. 4. Emergency lighting to the public way will be added on building safety checklist to ensure they are working properly.	8/31/13

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K 045	Continued From page 2 paths that were also on emergency lighting to the public way. The findings include: Observation and interview with the Maintenance Director, on July 29, 2013 at 1:45 p.m. confirmed outside lights were not provided for the exit sidewalks from the station 2 long hall and exit by the laundry to the public way. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 29, 2013.	K 045		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	1. The plastic trash receptacle has been removed from the smoking area. The smoking area is provided with a metal container with self-closing cover. 2. No other areas were found to be affected by same occurrence. 3. Maintenance Director has been instructed on proper containers required in a smoking area. 4. Maintenance will include smoking area on safety checklist.	8/31/13

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K 066	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined smoking areas were provided with metal containers with self-closing cover devices. The findings include: Observation and interview with the Maintenance Director, on July 29, 2013 at 3:55 p.m. confirmed the smoking area had a plastic trash receptacle. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 29, 2013.	K 066		

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